FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 140	Medicaid Provider Inquiry	06/2007
DHHS 142	Request for Medicaid Forms and Publications	06/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	05/2007
	Authorization Agreement for Electronic Funds Transfer	01/2009
CMS-1500	Sample Health Insurance Claim Form	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice (three pages)	06/2007
	MAPPS Documentation Points	
	MAPPS Screening Form (three pages)	02/2009
	MAPPS Case Plan	03/2009
	MAPPS Counseling Form (two pages)	07/2005
	MAPPS Progress Report	04/2009
	Standing Order (Sample)	
DHHS 1723	Consent for Sterilization	06/2010

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:	
NPI or MEDICAID PROVIDER ID: (if applicable)	MEDICAID RECIPIENT ID NUMBER: (if applicable)
ADDRESS OF SUSPECT:	LOCATION OF INCIDENT:
	DATE OF INCIDENT:
COMPLAINT:	

NAME OF PERSON REPORTING: (Please print)	SIGNATURE OF PERSON REPORTING:	DATE OF REPORT

ADDRESS OF PERSON REPORTING:	TELEPHONE NUMBER OF PERSON REPORTING:
	SIGNATURE: (SCDHHS Representative Receiving Report)

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form)

Provider Address :

Provider City , State, Zip:

Total paid amount on the original claim:

Original CCN:

Provider ID:

NPI:

Recipient ID:

Adjustment Type:

◯ Void ◯ Void/Replace

Originator:

◯ DHHS ◯ MCCS ◯ Provider ◯ MIVS

Reason For Adjustment: (Fill One Only)

- ◯ Insurance payment different than original claim
- ◯ Keying errors
- ◯ Incorrect recipient billed
- ◯ Voluntary provider refund due to health insurance
- ◯ Voluntary provider refund due to casualty
- ◯ Voluntary provider refund due to Medicare
- ◯ Medicaid paid twice - void only
- ◯ Incorrect provider paid
- ◯ Incorrect dates of service paid
- ◯ Provider filing error
- ◯ Medicare adjusted the claim
- ◯ Other

For Agency Use Only

Analyst ID:

- ◯ Hospital/Office Visit included in Surgical Package
- ◯ Independent lab should be paid for service
- ◯ Assistant surgeon paid as primary surgeon
- ◯ Multiple surgery claims submitted for the same DOS
- ◯ MMIS claims processing error
- ◯ Rate change
- ◯ Web Tool error
- ◯ Reference File error
- ◯ MCCS processing error
- ◯ Claim review by Appeals

Comments:

Signature:_____ Date:_____

Phone:_____

DHHS Form 130 Revision date: 03-13-2007

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

MEDICAID PROVIDER INQUIRY

MAIL TO: ATTENTION _____ UNIT S.C. DEPT. OF HEALTH AND HUMAN SERVICES POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206	TODAY'S DATE: NPI or MEDICAID PROVIDER ID: TELEPHONE:
PROVIDER NAME AND ADDRESS:	TYPE OF PROVIDER (i.e., Dentist, Group, etc.) DATE CLAIM FILED:

----------FOLD HERE----------

PATIENT'S NAME (First, Initial, Last)	MEDICAID NUMBER (10 Digits)	DATE OF SERVICE
HAS THE CLAIM APPEARED ON THE PROVIDER'S REMITTANCE ADVICE? (CHECK ONE) ☐ YES ☐ NO	IS MEDICARE COVERAGE INVOLVED? ☐ YES ☐ NO	
CLAIMS STATUS ON REMITTANCE ADVICE	PAYMENT DATE	17-DIGIT CLAIM REFERENCE NUMBER
STATEMENT OF PROBLEM OR QUESTION		
	SIGNATURE OF PROVIDER	
RESPONSE		
	AGENCY REPRESENTATIVE	DATE

SCDHHS Form 140 (revised 06/07)

STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH
AND HUMAN SERVICES

REQUEST FOR MEDICAID FORMS AND PUBLICATIONS

WHEN COMPLETED PLEASE FORWARD TO: SC DEPARTMENT OF HEALTH AND HUMAN SERVICES SUPPLY POST OFFICE BOX 8206 COLUMBIA, SOUTH CAROLINA 29202-8206 ***-OR-*** **FAX TO: (803) 898-4528**	NPI or MEDICAID PROVIDER ID: TYPE OF PROVIDER: TELEPHONE: - - CONTACT NAME:

NAME OF PROVIDER

STREET ADDRESS FOR UPS DELIVERY ***(PLEASE PRINT OR TYPE)***

ITEMS REQUESTED

FORM/PUBLICATION NO.	TITLE OF FORM OR PUBLICATION	QUANTITY

SCDHHS FORM 142 (revised 06/07)

South Carolina Department of Health and Human Services
Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must be completed. **Attach appropriate document(s) as listed in item 8.**

1. Provider Name: _____

2. Medicaid Legacy Provider # ☐☐☐☐☐☐
(Six Characters)

OR

3. NPI# ☐☐☐☐☐☐☐☐☐☐ **& Taxonomy** ☐☐☐☐☐☐☐☐☐☐

4. Person to Contact: _____ **5. Telephone Number:** _____

6. Reason for Refund: [check appropriate box]

☐ Other Insurance Paid (please complete **a – f** below and attach insurance EOMB)
- **a** Type of Insurance: ( ) Accident/Auto Liability ( ) Health/Hospitalization
- **b** Insurance Company Name _____
- **c** Policy #:_____
- **d** Policyholder: _____
- **e** Group Name/Group: _____
- **f** Amount Insurance Paid:_____

☐ Medicare
- ( ) Full payment made by Medicare
- ( ) Deductible not due
- ( ) Adjustment made by Medicare

☐ Requested by DHHS (please attach a copy of the request)

☐ Other, describe in detail reason for refund:

_____
_____
_____
_____

7. Patient/Service Identification:

Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund

8. Attachment(s): [Check appropriate box]

☐ Medicaid Remittance Advice (required)

☐ Explanation of Benefits (EOMB) from Insurance Company (if applicable)

☐ Explanation of Benefits (EOMB) from Medicare (if applicable)

☐ Refund check

Make all checks payable to: South Carolina Department of Health and Human Services
Mail to: SC Department of Health and Human Services
Cash Receipts
Post Office Box 8355
Columbia, SC 29202-8355

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Provider or Department Name: _____ Provider ID or NPI: _____

Contact Person: _____ Phone #: _____ Date: _____

I ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID#: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employer's Name/Address: _____

II CHANGES TO AN INSURANCE RECORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS

_____ a. beneficiary has never been covered by the policy – close insurance.

_____ b. beneficiary coverage ended - terminate coverage (date) _____

_____ c. subscriber coverage lapsed - terminate coverage (date) _____

_____ d. subscriber changed plans under employer - new carrier is _____

- new policy number is _____

_____ e. beneficiary to add to insurance already in MMIS for subscriber or other family member.

(name) _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM.

Submit this information to Medicaid Insurance Verification Services (MIVS).

Fax:	**or**	**Mail:**
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804

III NEW POLICY NUMBERS FOR INSURANCE IN THE MMIS WITH THE SUBSCRIBER SSN (SCDHHS is collecting new unique policy numbers and plans to replace existing insurance records through MMIS online modification as computer resources are available.)

Medicaid Beneficiary ID: _____ SSN: _____

Carrier Name/Code: _____ New Unique Policy Number: _____

Submit this information to South Carolina Department of Health and Human Services (SCDHHS).

Fax:	**or**	**Mail:**
803-255-8225		Post Office Box 8206, Attention TPL Columbia, SC 29202-8206

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
REASONABLE EFFORT DOCUMENTATION

PROVIDER _____ DOS _____

NPI or MEDICAID PROVIDER ID _____

MEDICAID BENEFICIARY NAME _____

MEDICAID BENEFICIARY ID# _____

INSURANCE COMPANY NAME _____

POLICYHOLDER _____

POLICY NUMBER _____

ORIGINAL DATE FILED TO INSURANCE COMPANY _____

DATE OF FOLLOW UP ACTIVITY _____

RESULT:

FURTHER ACTION TAKEN:

DATE OF SECOND FOLLOW UP _____

RESULT:

I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAYMENT OR SUFFICIENT RESPONSE FROM THE PRIMARY INSURER.

_____

(SIGNATURE AND DATE)

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

Revised 05/2007

South Carolina
Department of Health and Human Services
Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION

Provider Name _____

Medicaid Provider Number _____

Provider NPI Number _____

Provider Address _____

City _____ State _____ Zip _____

BANKING INFORMATION (Please include a copy of the electronic deposit information on bank letterhead. This is required and the information will be used to verify your bank account information).

Financial Institution Name _____

Financial Institution Address _____

City _____ State _____ Zip _____

Routing Number (nine digit) _____

Account Number _____

Type of Account (check one) ☐ Checking ☐ Savings

I (we) hereby authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to my account indicated below and the financial institution named below, to credit and/or debit the same to such account. These credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider.

I (we) understand that credit entries to the account of the above named payee are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws.

I (we) certify that the information shown is correct. I (we) agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

Contact Name: _____ Phone Number: _____

Signed _____ *(Signature)*

_____ *(Print)*

Title _____ Date _____

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

RETURN COMPLETED FORM TO:

Department of Health and Human Services
Medicaid Provider Enrollment
P.O. BOX 8809, COLUMBIA, S.C. 29202-8809
FAX (803) 699-8637

EFT/Revised 01/09

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGN

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

RUN DATE 05/01/2007 000001204 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES CLAIM CONTROL #9999999999999999A
REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 1136 ECF 1136 PAGE 1 OF 1
ANALYST ID HIC - 60 PRAC SPEC - 12 EMC Y
SIGNON ID DOC IND N ORIGINAL CCN:
TAXONOMY: SFL ZIP: PRV ZIP: ADJ CCN:

1	2	3	4	5	6	7	8	9
PROV/XWALK ID	RECIPIENT ID	P AUTH NUMBER	TPL	INJURY CODE	EMERG	PC COORD	---- DIAGNOSIS ---- PRIMARY	SECONDARY
ABC123	1111111111						170.1	.

NPI: 1234567890

EDITS
INSURANCE EDITS

CLAIM EDITS

LINE EDITS
01) 510

10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F

13 RES	14 ALLOWED	15 LN NO	16 DATE OF SERVICE	17 PLACE	18 PROC CODE	19 MOD	20 INDIVIDUAL PROVIDER	21 CHARGE IND	22 PAY	UNITS
	.00	1	05/07/02	11	S9445	OFP	XXXXXX	250.00		1.000

23 NDC

NPI: 1234567890 TAXONOMY:
2 / /
NPI: TAXONOMY:
3 / /
NPI: TAXONOMY:
4 / /
NPI: TAXONOMY:
5 / /
NPI: TAXONOMY:
6 / /
NPI: TAXONOMY:
7 / /
NPI: TAXONOMY:
8 / /
NPI: TAXONOMY:

24 INS CARR NUMBER	25 POLICY NUMBER	26 INS CARR PAID
01		
02		
03		

27 TOTAL CHARGE 250.00
28 AMT REC'D INS
29 BALANCE DUE 250.00
30 OWN REF # 5741-2

AGENCY USE ONLY
APPROVED EDITS
REJECTED LINE EDITS

CLAIMS/LINE PAYMENT INFO	
EDIT	PAYMENT DATE

RESOLUTION DECISION ___

ADDITIONAL DIAG CODES: . . . . . .

RETURN TO:
MEDICAID CLAIMS RECEIPT
P. O. BOX 1412
COLUMBIA, S.C. 29202-1412

INSURANCE POLICY INFORMATION

PROVIDER:
ABC TEEN SERVICES
PO BOX 00000
ANYWHERE XO 00000-0000

"PLEASE NOTE: EDIT CORRECTION FORMS RETURNED TO DHHS WITH NO CORRECTIVE ACTION WILL BE DISREGARDED"
* INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 1)

This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

AB0008 ABC TEEN SERVICES PO BOX 000000 FLORENCE SC000000000

.121212121234. Y

PROVIDER ID. PROFESSIONAL SERVICES PAYMENT DATE PAGE

AB00080000 | DEPT OF HEALTH AND HUMAN SERVICES | REMITTANCE ADVICE | 03/26/2007 | 1

SOUTH CAROLINA MEDICAID PROGRAM

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT	MEDICAID	T S	RECIPIENT ID. NUMBER	RECIPIENT NAME F M I I LAST NAME	M O D	TLE. 18 ALLOWED CHARGES	COPAY AMT	TITLE 18 PAYMENT
ABB222222	0406001089000400A				1192.00	243.71		P	1112233333	M CLARK			0.00	
	01		021507	S9445	800.00	117.71		P			0FP			0.00
	02		021507	H1010	392.00	126.00		P			0FP			0.00
	VOID OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0406001089000400U				1412.00-	273.71-			1112233333	M CLARK				
	01		012107	S9445	1112.00-	143.71-					0FP			
	02		012107	H1010	300.00-	130.00-					OFP			
	REPLACEMENT OF ORIGINAL CCN 0404711253670430A PAID 02/28/04													
ABB222222	0407701389002500A				1001.50	42.75		P	1112233333	M CLARK			0.00	
	01		012107	S9445	142.50	42.75		P			0FP			0.00
	02		012107	H1010	859.00	0.00		R			0FP			0.00
	TOTALS		2		2193.50	286.46							0.00	0.00

$286.46

CERT. PG TOT	MEDICAID PG TOT
$0.00	$286.46

CERTIFIED AMT	MEDICAID TOTAL
$0.00	0.00

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL". IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

FEDERAL RELIEF | MAXIMUS AMT | CHECK TOTAL | CHECK NUMBER

STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

PROVIDER NAME AND ADDRESS

ABC TEEN SERVICES
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 2)

This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

CLAIM ADJUSTMENTS

PAYMENT DATE 03/26/2007

PAGE 2

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	PY IND	SERVICE RENDERED DATE(S) MMDDYY	PROC.	AMOUNT BILLED	TITLE 19 PAYMENT MEDICAID	ST	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME	F I	M I	ORG CHECK D	CHECK DATE	ORIGINAL CCN
ABB222222	0406001089000400U				513.00-	197.71-		1112233333	CLARK		M		022807	0404711253670430A
	01		012107	S9445	453.00	160.71-	P					OFP		
	02		012107	H1010	60.00	33.00-	P					OFP		
	TOTALS	1			513.00-	193.71-								

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	$243.71	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
$193.71-	

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
0.00	$50.00	4197304

PROVIDER NAME AND ADDRESS

ABC TEEN SERVICES
PO BOX 000000
FLORENCE SC 00000

Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows four gross-level adjustments.
Gross-level adjustments always appear on the final page of the Remittance Advice.

PROVIDER ID. AB11110000

DEPT OF HEALTH AND HUMAN SERVICES

SOUTH CAROLINA MEDICAID PROGRAM

ADJUSTMENTS

PAYMENT DATE 03/26/2007

PAGE 3

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME F M I	ORIG. CHECK DATE	ORIGINAL PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
TPL 2	04086000037000000U	-						DEBIT	-2389.05	
TPL 4	04086000047000000U	-						DEBIT	-1949.90	
TPL 5	04086000057000000U	-						DEBIT	-477.25	
TPL 6	04086000067000000U	-						DEBIT	-477.25	
							PAGE TOTAL:		5293.45	0.00

DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	FEDERAL RELIEF	TO BE REFUNDED IN THE FUTURE
0.00	0.00	0.00	0.00	0.00

ADJUSTMENTS	MAXIMUS AMT
0.00	0.00

YOUR CURRENT DEBIT BALANCE	CHECK TOTAL	CHECK NUMBER
5293.45	0.00	

PROVIDER NAME AND ADDRESS

ABC TEEN SERVICES
PO BOX 000000
FLORENCE SC 00000

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

DOCUMENTATION POINTS

S9445-FP **— Patient Education, not otherwise classified, non-physician provider, Individual, per session. Address a minimum of three (3) documentation points from the list below plus the client's response.**

S9446-FP **— Patient Education, not otherwise classified, non-physician provider, Group, per session. Address a minimum of five (5) documentation points from the list below plus the client's response.**

1) Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention
2) Information on the importance of family planning, responsible sexual behavior, and its effect on overall reproductive health
3) Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention
4) Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention
5) Discussion of the benefits of delaying pregnancy
6) Discussion of the long- and short-term health risks related to early sexual activity
7) Discussion of birth control methods, including abstinence, and the options available
8) Instruction on the proper and appropriate use of birth control methods
9) Importance of compliance with prescribed family planning methods and follow-up medical visits
10) Information on the benefits and risks of long-term birth control methods
11) Identification of family planning problems
12) Discussion of the availability of other health care resources related to family planning
13) Information on STDs and prevention of STDs as it relates to reproductive health and family planning

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

SCREENING FORM

1. Name of Participant: (First, Middle Initial, Last) _____
2. Age of Participant: _____ Date of Birth:_____ Gender: ☐ Male ☐ Female
3. Social Security #: _____ Medicaid # _____ Patient Account:_____
4. Eligibility: ☐ Medicaid ☐ Foster Care ☐ Child Protective Services
5. Date of Assessment: (Month, Date, Year) _____
6. Racial or Ethnic Background of Participant: (Check one)

   ☐ White or Anglo, Not of Hispanic Origin ☐ Black, Not of Hispanic Origin ☐ Hispanic

   ☐ American Indian ☐ Asian or Pacific Islander ☐ Other: _____
7. Special needs of the participant (Check All That Apply)

   ☐ None ☐ Attention Deficit Disorder (ADD) ☐ Learning Disability ☐ Emotionally Handicapped

   ☐ Other: (Specify) _____
8. Does the participant have a primary medical care provider? If so, name and address:

   _____

   Managed Care Plan_____
9. Parent/Guardian: _____ SSN: _____
10. Employment Status of the Mother/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other:_____
11. Employment Status of the Father/Guardian: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Other: _____
12. Marital Status of Parent (s): ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other: _____

Environmental

13. Address of Participant:

Street Address:		
Mailing Address: (If Different from Street Address)		
City/Town:	State:	Zip Code:
Telephone: (Home)	(Other)	☐ No Telephone

14. Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

15. Access to Transportation: (Check One) ☐ Yes ☐ No Comment _____

Referral/ Health Risk Factors

16. What was the referral source for MAPPS? (Check One)

☐ DSS ☐ Teacher ☐ Counselor ☐ Relative ☐ Friend ☐ Other: (Specify) _____

17. Referral Risk Factor (s): (Explain in Narrative)

☐ Participant is a Teen Parent ☐ Participant is Sexually Active ☐ Participant has a history of Sexual Abuse

☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent (give details)

18. Is the participant currently sexually active? ☐ Yes ☐ No

If no, has the participant ever been sexually active? ☐ Yes ☐ No

19. Has the participant ever been an expecting parent (abortion/fetal death)? ☐ Yes ☐ No

20. Has the participant ever used a birth control method? ☐ Yes ☐ No

Method Used: (Check All That Apply)

☐ Birth Control Pills ☐ Condom ☐ Depo-Provera Shot ☐ Diaphragm ☐ IUD ☐ Rhythm

☐ Other: _____

21. Does the participant understand or know the health risks associated with having sex? ☐ Yes ☐ No

22. Has the participant ever had a STD? ☐ Yes ☐ No If yes, specify: _____

23. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? ☐ Yes ☐ No

If yes, what kind? _____

Activities

24. Does the participant engage in extracurricular activities? ☐ Yes ☐ No

If yes, list activities: _____

25. How does the participant spend his/her free time?

After School: _____

Weekends: _____

26. Do household rules cause any conflict between the parent/guardian and the participant? ☐ Yes ☐ No

If yes, explain: _____

_____

What are the parent/guardian's and the participant's feelings about the household rules? _____

_____

27. Does participant have friends? ☐ Yes ☐ No

If yes, gender and age? _____

When they spend time together, what do they do? _____

How does the participant get along with friends? _____

28. How does the participant get along with adults? (Including teachers)_____

_____

_____

SCREENING/NEEDS ASSESSMENT

(T1023-FP)

Participant's Name: _____

Date of Service: _____ **Medicaid Number**: _____

Units: _____

(Provider of Service)
Licensed/Certified Signature: _____ Date: _____

Medicaid Adolescent Pregnancy Prevention Services

CASE PLAN

Treatment Protocol (T1023-FP)

Participant's Name _____ Medicaid Number _____

Needs Statement: _____

Plan of Care: _____

Goals and Objectives	Frequency	Completion Date*

*A Progress Report must be sent to the Primary Care Physician when services are completed.

This ICP will be reviewed on (6 months from ICP date): _____

Participant's Signature: _____ Date: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Provider of Service: _____ Date: _____
(Licensed/Certified Signature and Title)

Units: _____

Date Reviewed: _____ (Review case plan during Individual Session)

Progress Report prepared by: _____ Date: _____

Mailed to: _____ Date: _____
(Primary Care Physician)

03/09

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES

INDIVIDUAL OR GROUP SESSION FORM

Participant's Name: _____

Date of Service: _____ **DOB**: _____ **Age**: _____

Medicaid Number: _____ ☐ **Individual** ☐ **Group**

Place: **Units of Service:** _____

☐ Participant's Home ☐ Office ☐ School ☐ Other

Risk Factors: (Check All That Apply)

☐ Parent (s) were Teen Parents ☐ Sibling is Pregnant and/or Teen Parent

☐ Participant is a Teen Parent ☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent

☐ Participant is sexually and/or has a history of sexual abuse

A narrative description of services must be provided. Documentation of session must support time billed and points discussed. Check the Documentation Points discussed:

☐ 1. Discussion of adolescent development as it relates to human growth, development, sexuality, and pregnancy prevention

☐ 2. Information on the importance of family planning, responsible sexual behavior, and its affect on overall reproductive health

☐ 3. Discussion of the benefits of abstinence as it relates to normal growth and development for teens and pregnancy prevention

☐ 4. Discussion of the benefits of delaying sexual activity as it relates to healthier birth outcomes and pregnancy prevention

☐ 5. Discussion of the benefits of delaying pregnancy

☐ 6. Discussion of the long and short-term health risks related to early sexual activity

☐ 7. Discussion of birth control methods, including abstinence, and the options available

☐ 8. Instruction on the proper and appropriate use of birth control methods

☐ 9. Importance of compliance with prescribed family planning methods and follow up medical visits

☐ 10. Information on the benefits and risks of long term birth control methods

☐ 11. Identification of family planning problems

☐ 12. Discussion of the availability of other health care resources related to family planning

☐ 13. Information on STDs and prevention of STDs as it relates to reproductive health and family planning

PATIENT EDUCATION

☐ Individual ☐ Group

Participant's Name: _____

Date of Service: _____ **Medicaid Number**: _____

Service Provider

SIGNATURE (and credentials): _____ Date: _____

Supervisor

CO-SIGNATURE (and credentials) _____ Date: _____

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

PROGRESS REPORT

Reason for Communication: ☐ **Admission** ☐ **Progress Report** ☐ **Discharge**

Primary Care Physician _____

Address _____

_____

Phone/Fax _____

Name of Client:_____ **Date of Birth:**_____

Date MAPPS Services Started:

Reason For Service Provision (Risk Factor):

Client Assessment:

Status of Mutually Agreed Upon Goals/Target Dates:

Status of Plan of Care (Services/Frequency):

Continued Services Needed? _____ **Yes** _____ **No**
If Yes – Anticipated Services, Frequency, and Completion Date(s):

MAPPS Provider:

Signature of MAPPS Provider and Date:

STANDING ORDER (SAMPLE)

In order for individuals to maintain an optimal state of health, it is imperative that they be linked with a Primary Care Physician (PCP) who provides medical preventive and acute care, that they use care appropriately, and that they practice healthy behaviors. ***(Insert Name of Facility)*** staff may perform the following PSPCE and RSPCE:

- Assessment provided by Licensed Practitioner of the Healing Arts (LPHA) to determine client strengths, resources, perceptions of need relative to appropriate use of primary medical care, and practice of healthy behaviors;
- Evaluation of information and developing a plan of care in conjunction with the patient and PCP (must be verbal or written) which addresses health-related, medical, and developmental risks/needs appropriate for P/RSPCE;
- Determination of the patient's risks and his or her readiness for intervention;
- Determination of interventions indicated, and whether interventions should be PSPCE or RSPCE;
- Implementation, coordination, and monitoring of the plan of care to determine patient progress toward goal achievement;
- Ongoing reassessment to determine necessary changes in the plan of care and/or interventions;
- Communication (must be verbal or written) will be maintained and documented in the clinical record during all phases of the patient's care; and
- Identification of PCP (medical home):
    1. It is the responsibility of the PSPCE or RSCPE provider to assist the patient in locating a PCP within six months; to obtain permission to share PSPCE or RSPCE information with the PCP; and to communicate (must be verbal or written) the activities to the PCP during all phases of the patient's care.
    2. This Standing Order may be used to authorize provision of PSPCE or RSPCE as long as efforts are being made to locate a PCP for the patient, but no longer than six months.

PSPCE may be provided by a LPHA as determined in the assessment in order to:

- prevent disease, disability, and other health conditions or their progression;
- prolong life; and
- promote physical and mental health efficiency.

PSPCE promotes full and appropriate use of medical care, promote positive health outcomes, prevents deterioration of chronic conditions, and enhances the practice of healthy behaviors.

RSPCE may be recommended by LPHA as determined in the assessment in order to reduce physical or mental disability and restore an individual to his or her best possible functioning level. This service also promotes changes in behavior, improves health status, and develops healthier practices to restore and maintain the patient at the highest possible functioning level.

P/RSPCE Dental Services

_____ _____

Signed by Date

Documentation Note: If this Standing Order is being used to authorize PSPCE or RSPCE, a copy must be placed in the patient's chart.

State of South Carolina
Department of Health and Human Services

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

_____ (*Medicaid ID*)

You are requested to supply the following information, but it is not required:
(Ethnicity and Race Designation) (please check)

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

DHHS 1723 (06/2010)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/She will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)